IMPROVING CHEMICAL HEALTH TREATMENT SERVICES

Dakota County Community Corrections Advisory Board Report on

Improving Chemical Health Treatment Services and Outcomes For Offenders

Executive Summary

Dakota County Community Corrections (DCCC) faces a difficult dilemma. DCCC staff must effectively address the criminal justice system's need to place a large number of adult and juvenile offenders in chemical dependency treatment, while faced with limited financial resources. The growing number of incarcerated offenders with mental health problems further exacerbates the issue. From 1990 to 2001, the number of persons with mental illness in prison rose 92 percent. Nationwide, 16 percent of incarcerated offenders are mentally ill. According to a recent article by the New York Times, on any day, almost 200,000 offenders behind bars are known to suffer from schizophrenia, manic-depression, or major depression, the three most severe mental illnesses. In the case of juvenile offenders, research indicates that chemical abuse is related to recurring, chronic, and violent delinquency that continues well into adulthood. Juvenile chemical abuse is also strongly related to deteriorating and/or disrupted family relationships, poor and/or inappropriate peer relationships, learning disorders, exposure to high levels of trauma and violence, and other psychological, medical, and/or social problems. While very little data are presently available about juveniles with chemical and mental health problems, it has been estimated that nationwide up to 60 percent of juveniles who are involved in the justice system have such disorders.

The problems relating to criminal behavior, chemical abuse and mental illness have traditionally been dealt with separately, by systems designed expressly for each purpose. The relationship between crime, chemical abuse and mental illness is intricately connected; and fragmented services can result in offenders receiving inappropriate services. While much is known about this problematic relationship overall, there is still a need for research and evaluation of chemical health assessment, treatment, and intervention services to promote effective program development and policy implementation. DCCC is well aware that one important part of any effective solution is to ensure that offenders with co-existing (mental and chemical abuse) disorders are successfully connected with integrated community-based treatment services to break the cycle of criminal recidivism.

For 2002, Dakota County's Community Corrections Advisory Board's (CCAB) strategic planning objectives are to evaluate chemical health treatment services and outcomes, to affirm Community Corrections mission of promoting accountability and opportunity for positive change of the offender; and to recommend program and systems modifications to ensure that the delivery of needed services are consistent with the County's overall goal of providing efficient, effective and responsive public services, and Community Correction's goal of promoting public safety.

To facilitate the chemical health study, a Community Corrections planning team focused CCAB discussions on the following four research objectives:

- # 1: To assess and evaluate DCCC's offender population with chemical health issues.
- # 2: To assess chemical health treatment services available to DCCC offender population, beginning with assessment through treatment and ending with transitional services.
- #3: To learn more about chemical health treatment outcomes for offenders.
- # 4: To assess funding sources available to DCCC's offenders for chemical health treatment services.

Summary of Recommendations

The board's recommendations to DCCC for improving chemical health services for offenders are as follows:

Chemical Health Treatment

 Survey local treatment providers, insurance providers and individuals who receive treatment to learn more about why individuals do not complete treatment and how treatment barriers are addressed.

- Track and analyze treatment outcomes over time to measure system performance, examine effects of chemical use on criminal recidivism and determine appropriate resource allocations.
- Ensure that contracts with chemical health treatment providers offer integrated systems of care, and cultural and gender-specific programming.
- Implement a pilot in-patient CD treatment program at DCCC's Juvenile Services Center.
- Incorporate WRAP-AROUND services into chemical health treatment intervention services for juvenile offenders.
- Evaluate the possibility of using the WRAP-AROUND service model for adult offenders; if deemed appropriate, implement a WRAP-AROUND pilot project.
- Re-evaluate Safe Street First outcome data to prevent generalizing the program's effectiveness.
 DCCC may need to secure funding to conduct an in-depth assessment of SSF treatment outcome data to clearly determine whether or not the program is effective.

Continuing Care/Transitional Care Services (Aftercare)

- Evaluate the effectiveness of DCCC's Cognitive Behavioral/Chemical Dependency pilot project for adult offenders and explore this as an option for continuing care.
- Expand Multi-Systemic Therapy and WRAP-AROUND services as a component of continuing care services for juvenile offenders.
- Consult with insurance companies to develop incentives for service providers to fund chemical health continuing care services.
- Evaluate outcomes of continuing care services to determine the impact on the offender's success
 at remaining alcohol and drug free. Determine if current continuing care/transitional services are
 adequate to meet the needs of offenders.

<u>Funding</u>

- Collaborate with Hennepin and other interested counties in pursuing Medicaid dollars to pay for chemical health treatment services.
- Explore the possibility of expanding the Chemical Dependency Consolidated Treatment Fund.
- Explore legislation on court-ordered treatment as a way for insurance providers to pay for broader (dual diagnosis) treatment services.
- Evaluate the impact of new DWI laws and how to successfully incorporate statutory language requirements into treatment and intervention services.

Training

- Develop and implement cross-training among criminal justice agencies, social services agencies, and insurance companies to:
 - 1. provide information about the complex needs of offenders with chemical health issues,
 - 2. ensure that information provided to offenders about chemical health treatment services is consistent.
 - 3. improve offender access to services, and
 - 4. roll out "best practices" treatment approaches.

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Chemical Health Treatment Services and Outcomes For Offenders

Background

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Research Objective # 1: To assess and evaluate DCCC's offender population with chemical health issues.

Findings # 1: Demographics

According to the 2000 census data, Dakota County continues to be the third most populous county in Minnesota with a population of 355,904. In 1999, the Minnesota Bureau of Criminal Apprehension reported 17,727 adult and juvenile arrests and apprehensions for the County, of which 7,666 were for chemical abuse violations. In 2000, DCCC reported 15,757 adult and juvenile offenders under probation supervision for felony, gross misdemeanor and/or misdemeanor offenses.

At the front end of the County's correctional services (intake), an offender is interviewed and undergoes a risk and needs assessment to:

- identify overall risk factors for repeating criminal offenses, juvenile delinquency, chemical abuse, needs, strengths, and responsivity factors,
- guide the development of treatment plans and strategies, and
- assign a supervision level (refer to DCCC's 2002-2003 Comprehensive Plan, pages 49 & 54, to review adult and juvenile services classification of supervision levels) to effectively reduce the likelihood of re-offending.

The Level of Services Inventory-Revised (LSI-R) risks and needs assessment tool is used for adult offenders and the Youth Level of Service and Case Management Inventory (Y-LSCMI) is used for juveniles. Both are standardized correctional assessment tools that are widely used. The assessment combines evaluation of the offender's risk and criminogenic needs to produce a complete picture of those factors that predict criminal conduct. Adults who score 25 or higher on the LSI-R and juveniles who score 18 or higher on the Y-LSCMI are considered high-risk and are the best candidates for intervention services. Generally, offenders assessed as low risk succeed with less intense intervention services. When an assessment detects possible mental health problems, the offenders are referred to mental health professionals for further evaluation.

To further assist CCAB members in understanding the County's offender population with chemical health issues, DCCC staff initiated a preliminary analysis of adult and juvenile offender's LSI-R and Y-LSCMI scores and presented their findings at the September 2001 board meeting. A random sampling of 260 LSI-R scores showed that 161 (62%) adult offenders had chemical health issues. Eighty-percent of the adult sample population were male, 73 percent were white and the average age was 25 years. Thirty-five percent of the adult offenders did not live in Dakota County. Of the selected 360 juvenile offenders under supervised probation, 117 (32%) had chemical use as a major high risk factor. Ninety-five percent were male, 89 percent were white and the average age was 16 years.

Findings # 2: Case Studies

In October, Community Corrections staff presented an adult and juvenile offender case study to CCAB members. The adult case study was on a 40-year old Hispanic male currently on probation in Dakota County for a felony Controlled Substance Crime - 5th degree offense; and the juvenile study was on an 18-year old male involved in a felony Criminal Damage to Property offense and had been in and out of chemical and mental health treatment for the past three years. The following is an overview of both case studies:

Demographics	Case Overview of Adult Offender- Louis (alias)	
Demographics	> 40-year old single Hispanic male with 2 sons	
	> 3/27/2003 - probation expires	
	Systems Contact	
Police	> 12/03/1997 - arrested for Controlled Substance Crime (CSC) 5 th degree06/13/2001 – arrested for Driving Under the Influence (DUI) - Bail set @ \$8,000 07/15/2001 - Bailed out	
County Attorney	> 02/06/1998 - Complaint (Summons) for CSC	
Courts	> 04/06/1998 - 1st Hearing (CSC)	
	> 05/11/1998 - Omnibus hearing to determine if legal issues need to be resolved	
	> 07/07/1998 - Jury Trial - No Show - Warrant	
	> 07/09/1998 - Continuance -Turned Himself In-Released on Recognizance (R.O.R)	
	> 10/05/1998 - Plead to Charge	
	> 02/09/1999 - Sentenced -Stay of Adjudication	
	Terms/Conditions: (4) days jail, (26) days Sentenced to Serve (STS,) \$300 fine + 30 Surcharge, CD evaluation and follow recommendations, follow all aftercare, no use of alcohol or illegal drugs, random urine testing (UA's), follow rules of probation, and remain law abiding	
	> 03/09/1999 Court sentence on Misdemeanor DUI	
	Terms/Conditions: 1 year probation & \$275 fine	
	> 03/14/2000 - Probation Revocation (Pro-Rev) Hearing - No Show-Warrant issued	
	> 03/20/2000 - Turned himself in – Public Defender (PD) Denied-Paid \$200	
	> 03/28/2000 - Pro-Rev- Stay of Imposition	
	Terms/Conditions: same terms/conditions, start Safe Streets First, electronic home monitoring (EHM) immediately05/09/2000 - Probation Revocation Hearing	

	Terms/Conditions: Reinstate same terms/conditions, Start Safe Streets First by 06/01/2000 or serve 30 days
	> 09/24/2001 - First Hearing on a new offense
	> 10/18/2001 – Omnibus Hearing continued to 11/28/2001
Assessment/	> 02/18/1999 – Assigned to Intermediate Supervision for CSC
Probation / Case Management	> 03/09/1999 – Misdemeanor DWI assigned to same agent
	> 01/24/2000 – Violation report submitted to court
	> 04/05/2000 – Assigned to Safe Streets First agent
	> 05/04/2000 – Agent issued 72-hour custody hold for Cocaine use
	> 05/30/2000 – Agent issues a second 72-hour custody hold for Cocaine use
	> 06/01/2000 – Begin Safe Streets First program
	> 09/07/2000 – Agent issues a third 72-hour custody hold for missing appointments
	> 05/16/2001 – Completed Safe Streets First
	> 05/22/2001 – Supervision level reduced to low risk supervision unit
	> 07/16/2001 – Returned to Safe Streets First Agent (charged with two new offenses)

Demographics	Case Overview of Juvenile Offender- Brent (alias)	
Demographics	 18-year old male, lives w parents and has 4 younger siblings Student at an alternative learning school In and out of chemical and mental health treatment for the past three (3) years Private insurance 	
	Systems Contact	
Court Screening /Recommendations	 11/2000 involved in a Felony Criminal Damage to Property offense 01/2001 - appears in court Terms and Conditions: 30 hours community service, \$ 500.00 restitution Complete CD Evaluation -Follow recommendations, Pre-Y-LSCMI screening Supervised probation April 2001 - First appearance/continued pending a 30-day diagnostic evaluation June 2001 - Plead and Disposition Hearing which includes Chemical/Mental Health Treatment, probation until age 19 	
Assessment/ Probation / Case Management	 February 2001 - Probation Intake - parents to set up CD evaluation thru insurer February 2002 - Full Y-LSCMI completed April 2001 - Brent taken to detox and cited for possession of explosives and incendiary devices June 2001 - Placement at Cedar Ridge Treatment Program June 2001 - Placement and transport completed at Northland Recovery, Grand Rapids August 2001 - Placement at Cochran House August 2001 - Probation violation and detention for failure to complete Cochran House program September 2001 - Brent is referred to Fairview Maplewood October 2001 - Relapse happened over the weekend October 2001 - Continue treatment at Fairview Maplewood and commence aftercare December 2001 - Crisis (suicide attempt) admit to Abbot Northwestern Hospital January 2002 - Enrolled at South St. Paul High School as a junior February 2002 - Completed aftercare 	

Both case studies generated a lot of discussion among CCAB members, regarding the following issues:

- The length of time from the date of the offense to the sentencing date,
- The length of time from sentencing to probation contact,
- The length of time to process probation violation through the court system,
- Public safety during the offender's probationary period,
- The responsibility of the county, corrections, and the courts during probation,
- The lack of significant incarceration or other serious consequences after having multiple violations of probation conditions,

- The investment of staff time throughout the system (police, courts, sheriff, corrections) in supervising one offender,
- A better understanding of why and when Apprehension and Detention Orders (A&D Order) are issued.
- Hennepin County's "Drug Court" as an example of what appears to be a speedier way of handling drug related cases.

After the presentation of the case studies, Community Corrections planning team felt that board members had a better understanding of the criminal justice system and the issues involved when offenders have co-existing chemical and mental health problems.

Findings # 3: Tracking Offenders Who Get Treatment

In Minnesota, we are fortunate to have a well-established tracking system for individuals in chemical health treatment. The Drug and Alcohol Normative Evaluation System (DAANES) was established in 1983 and collects data from all treatment programs in the state, both public and private, and approximately 35 detoxification facilities. Most of the data collected by the planning team on chemical health treatment outcomes for this report were compiled from DAANES state and county reports, and other reference sources as indicated.

In 2001, 37,652 Minnesota residents entered chemical dependency treatment, of which 1,972 were from Dakota County. Of the 1,972 county residents, 1,104 (56%) entered treatment under the jurisdiction of the courts, i.e. they had an arrest or conviction within the last six months, they were given a choice between treatment and jail, or they entered treatment as a condition of probation or parole. This last category accounted for 25 percent of these court-ordered treatment admissions.

In both the state and county, 80 percent of chemical dependency treatment admissions were related to alcohol or marijuana abuse and 70 percent of the individuals in treatment were males. The average age for all individuals in treatment was 32 years, specifically; most were between ages 24 - 44 years old. Approximately 34 percent of individuals in treatment from Dakota County were adolescents or young adults under age 25. Eighty-nine percent were white, nine percent were from communities of color and the remaining two percent were considered bi-racial or race/ethnicity unknown.

An offender's initial contact with the criminal justice system is by police arrest. The next contact is with the courts. Judges can refer offenders to chemical health treatment programs and provide sanctions, which mandate that they remain in treatment, ensuring that offenders are motivated to stay in treatment.

Conclusions:

- Classification and assessment of an offender's risk and criminogenic needs help correctional staff better understand both the likelihood of criminal recidivism and treatment relapse, and help to develop strategies to reduce chances of failure.
- Classification and assessment scores are used to describe the offender population, quantify and allocate limited resources (number of staff, staff time and dollars for services, etc.), and assess the effectiveness of community supervision as it relates to public safety.
- Cross-training of criminal justice staff, social services staff and insurance providers is crucial to
 developing an understanding of the complex needs of offenders, and the systems and referral
 options available for chemical health treatment programming (including educational programming,
 primary outpatient programming and inpatient programming).

Research Objective # 2: To assess chemical health treatment services available to DCCC offender population,

beginning with assessment through treatment and ending with transitional services

Findings # 1: Best Practices in Treatment Approaches

Numerous research studies indicate that treatment works to reduce/prevent chemical abuse and criminal behaviors for adult and juvenile offenders. Most of these studies conclude that effective CD treatment programming includes:

• <u>Family involvement in treatment services:</u> Family-focused interventions have shown positive impacts on offender and family functioning, criminal and delinquent behavior and criminal recidivism. Families have a wealth of information about an offender's strengths and needs and

should be involved in developing individualized treatment and aftercare plans. In the case of juvenile offenders, families should also receive regular progress reports on all medical, chemical health, mental health, educational and other services their child receives.

- Structured, intensive and focus on changing specific behaviors: The most effective treatment programs typically involve cognitive training and/or behavior modification techniques aimed at reducing risk factors for involvement in the criminal justice system. For example, programs, which focus on improving interpersonal skills, self-control, anger management, and chemical abuse resistance, have been found to reduce criminal recidivism and treatment relapse. Treatment that is longer in duration and involves more contact hours is associated with better outcomes. For programs based in institutional settings, better outcomes are associated with the use of mental health professionals rather than corrections staff as the treatment providers. In general, the most effective programs are highly structured, emphasize the development of basic cognitive and social skills and provide individual counseling that directly addresses behavior, attitudes and perceptions.
- Integrated, multi-treatment approaches are essential: Many offenders in the justice system are involved in other care systems as well, such as mental health, social services, education, or public health. These offenders are best served when agencies coordinate care and supports systems around the offender and family in an individualized way. Multi-model or multi-component interventions are more effective for offenders than narrowly focused programs. Integrated chemical abuse and mental health treatment is also considered state-of-the-art for offenders with co-occurring disorders.² Integrated systems of care typically involve collaboration across a number of public agencies with the goal of developing coordinated plans for family-centered, community-based services, building upon offender and family strengths.
- Ineffective treatment approaches: In reviewing national research on ineffective treatment programs for adult and juvenile offenders, a number of studies have found that punishment is not effective as a deterrent and does not reduce criminal recidivism in the long run. Another review of the literature concluded that various types of punishment-including regular incarceration and "scared straight" programs-actually produced higher criminal recidivism rates among juvenile than no punishment at all. Other programs (as a sole sanction) found to be ineffective in reducing criminal recidivism are increased surveillance, unstructured counseling, home confinement, frequent drug testing, electronic monitoring and boot camps.

Findings # 2: Community-Based Treatment Modalities & Approaches

CCAB members learned that there are many community-based chemical health treatment models. To narrow the focus, the planning team pulled together a panel of chemical health treatment experts to present information on their agency's treatment philosophies, supporting theories, treatment, aftercare services, and individuals they successfully serve. The following is a synopsis of their February 2002 presentations:

 Minnesota Model/12 Step Model – Deb Schneling, Avalon-Meridian Behavior Health Network

<u>Philosophy and supporting theories:</u> The Minnesota Model was developed in the 1950's and first used by the Hazelden Foundation. The Minnesota Model views chemical addiction as a primary, chronic and progressive disease:

- primary an entity in itself and not caused by other factors,
- chronic the individual cannot return to "normal" chemical use once the addition is established, and
- progressive symptoms and consequences continue to occur with increasing severity as use continues or resumes.

The Minnesota Model is characterized by a thorough on-going assessment of all aspects of the individual (holistic approach) and by multi-therapeutic approaches (team approach, matching services to individualized needs). The main agent of change is through a positive peer culture

¹ Lipsey, M., & Wilson, D. (1998). Effective intervention for serious juvenile offenders: A synthesis of research. In R. Loeber & D. Farrington (Eds.), *Serious and Violent Juvenile Offenders*. Sage Publications: Thousand Oaks, CA. ² Riggs, P. (1998). Clinical approach to treatment of ADHD in adolescents with substance use disorders and conduct disorder. *Journal of American Academy of Child and Adolescent Psychiatry*, *37*(*3*), 331-333.

within a group approach. 12-Step principles are incorporated and referrals to 12-Step and other abstinence based support groups are made.

Under the Minnesota Model, diagnosis is commonly made using the Diagnostic and Statistical Manual IV (DSM-IV) of mental health disorders. The Minnesota Model has been effective in improving the lives of hundreds of thousands of chemically dependent individuals and their family members. The primary treatment goal of the Minnesota Model is lifetime abstinence from alcohol and other mood-altering substances with improved quality of life. Additional goals include making positive changes in thinking (cognition) and behavior, management of emotions, attention to family, psychological, spiritual, vocational, educational, medical and/or physical needs.

The Avalon-Meridian Behavior Health Network provides a range of in-patient and outpatient services: The Network serves offenders as well as other individuals seeking treatment, offers coed and gender specific programming and provides treatment for dual-diagnosed individuals.

<u>Populations served:</u> Appropriate for individuals who meet the Diagnostic and Statistical Manual IV criteria for mental health disorders.

<u>Populations that would not benefit from this treatment philosophy</u>: Individuals not meeting program criteria and individuals with no interest in remaining abstinent.

<u>Relapse Prevention and aftercare services:</u> Under the Minnesota Model, dependency and addiction as an illness often includes relapse. Relapse offers an opportunity for the individual to further his/her understanding, growth and change. Improvement of quality of life, saving in dollars and reduction in criminal recidivism occurs even with relapses. Avalon-Eagan offers outpatient treatment, relapse prevention and community integration programs.

• Therapeutic Community Model - Dan Cain, RS Eden

<u>Philosophy and supporting theories:</u> The Therapeutic Community Model is an intensive and comprehensive treatment model for use with adults and adolescents with chemical addictions. This model originated in 1958, a time when other systems of therapy, such as psychiatry and general medicine, were not successful in treating alcohol or chemical abuse. The first Therapeutic Community Model for chemical abusers (Synanon) was founded in California.

The core goal of the Therapeutic Community Model has always been to promote a more holistic lifestyle and to identify areas for change such as negative personal behaviors--social, psychological, and emotional--that can lead to chemical abuse. In the early Therapeutic Community Model, punishments, contracts, and extreme peer pressure were commonly used. Partly because of these methods, the Therapeutic Community Model had difficulty winning acceptance by professional communities. It is now an accepted modality in the mainstream treatment community. The use of punishments, contracts, and similar tools has been greatly modified, although peer pressure has remained an integral and important therapeutic technique.

The Therapeutic Community Model has been modified over time to include a variety of additional services not provided in the early years, including various types of medical and mental health services, family therapy and education, and vocational services. A primary distinction between the Therapeutic Community approach and 12-Step-based programs is the belief that the individual is responsible both for his addiction and for his recovery. Where AA says, "let go, let God," the Therapeutic Community Model approach takes the view that "you got yourself here, now you have to get yourself out with the help of others."

<u>Populations served:</u> Appropriate for individuals motivated to change their drug/alcohol use behavior.

<u>Populations that would not benefit from this treatment philosophy:</u> Does not work for individuals who are not motivated to change their drug/alcohol use behavior.

<u>Relapse Prevention and aftercare services:</u> Recovery is seen as changing negative patterns of behavior, thinking, and feeling that predispose one to chemical abuse and developing a responsible chemical-free lifestyle. It is a developmental process in which an individual develops the motivation and know-how to change his/her behavior through self-help and social learning. The Therapeutic Community Model is a highly structured, well-defined, and continuous process of self-reliant program operation. The use of the community itself as therapist and teacher in the treatment process is very important in relapse and aftercare.

Cognitive Behavioral Therapy Approach – (CBT) Brian Sammon, Community Drug & Alcohol Services. Inc.

<u>Philosophy and supporting theories</u>: The CBT Model is based on cognitive therapy, which is a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behavior by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions (Beck et al. 1993). The CBT Model involves individuals learning how their thoughts, feelings and behaviors (especially drinking/using behaviors) are connected, and how to break those connections.

The CBT Model is a focused approach to helping chemically dependent individuals overcome alcohol and chemical abuse. The underlying assumption is that the learning processes play an important role in the development and continuation of alcohol and drug abuse and dependency. CBT attempts to help individuals recognize the situations in which they are most likely to use alcohol and/or other drugs, avoid these situations when appropriate, and cope more effectively with a range of problems and problematic behaviors associated with chemical abuse.

The CBT Model is particularly similar to cognitive therapy in its emphasis on functional analysis of chemical abuse and identifying cognitions associated with chemical abuse. It differs from cognitive therapy primarily in terms of emphasis on identifying, understanding, and changing underlying beliefs about the self and the self in relationship to chemical abuse as a primary focus of treatment. In the initial sessions of CBT, the focus is on learning and practicing a variety of coping skills, only some of which are cognitive. Initial strategies stress behavioral aspects of coping (e.g., avoiding or leaving the situation, distraction, and so on) rather than a person trying to think his or her way out of a situation.

<u>Populations served:</u> Appropriate for individuals who are medically stable and willing to develop ways of coping and modifying their drug/alcohol behaviors.

<u>Populations that would not benefit from this treatment philosophy:</u> Not appropriate for individuals who have psychotic or bipolar disorders and are not stabilized on medication, and who do not have stable living arrangements.

<u>Relapse Prevention and aftercare services:</u> CBT requires participation in relapse prevention group therapy. Community Drug & Alcohol Services, Inc. offers continuing care planning. Accountability is very high for program participants. For drug and alcohol abusers, community integration is initially a 3-month long process, supported by formal and informal community support systems.

Responsible Use Model - Judy Gordon, CREATE

<u>Philosophy and supporting theories:</u> CREATE's approach and chemical health philosophy can best be described as: Negotiating the CHOICES individuals must make in order to attain a state of HEALTH; teaching people to develop goals and negotiate methods for achieving those goals; encouraging individuals to confront themselves with their personal truths and designing ways to live with the choices and situations each person has in his (her) life; and assisting individuals in deciding what best describes RESPONSIBLE DECISION MAKING in reference to CHEMICAL USE.

<u>Populations served:</u> Appropriate for individuals who are medically stable and willing to take responsibility for their alcohol/chemical use.

<u>Populations that would not benefit from this treatment philosophy:</u> Individuals not motivated to change their drug/alcohol use behavior.

<u>Relapse Prevention and aftercare services:</u> Relapse and aftercare services help individuals to examine patterns and self-defeating behaviors and formulate plans to reduce or eliminate future risk.

Findings # 3: DCCC Intervention Programs and Services

Safe Streets First (SSF) Intervention Program Services

<u>Philosophy and supporting theories:</u> Safe Streets First is a combination chemical dependency treatment and surveillance program primarily for people with three or more DWI offenses. An initial SSF screening takes place at the time of sentencing. If an offender meets the criteria for

SSF services, the judge will sentence them to the program. In some cases, offenders will serve the first part of their sentence in jail then enter Safe Streets First.

Primary treatment incorporates the 12-Step approach in addition to other treatment modalities. The focus is to help offenders accept their chemical dependency and give them skills to assist them in leading an alcohol free lifestyle. Cognitive Skills Training provides an opportunity to learn new and positive thinking skills in order to better handle social and personal problems.

SSF requires participants to remain chemically free starting the day the judge sentences them to the program. Any use or possession of alcohol, any type of mood altering chemicals or non-prescribed drugs will result in immediate detention or other disciplinary action. Compliance with this condition is tested regularly through random drug testing. Failure or refusal to submit to a drug test is considered as a positive test.

<u>Populations served:</u> Appropriate for individuals that meet SSF program criteria and are court-ordered for services.

<u>Populations that would not benefit from this treatment philosophy:</u> Individuals who have limited cognitive skills.

<u>Relapse Prevention and aftercare services:</u> SSF program services include aftercare and relapse prevention training. Relapse Prevention gives offenders insight and skills to prevent relapse and maintain long term sobriety.

Cognitive Behavioral/Chemical Dependency - Pilot Project for Adult Offenders

<u>Philosophy and supporting theories:</u> DCCC's Adult Services Unit recently implemented a Cognitive Behavioral/Chemical Dependency (COG/CD) program. Twelve offenders male are participating in the program. All are on probation and have had previous chemical health treatment services. The COG/CD curriculum is specifically designed for adult offenders who are chemical abusers.

Cognitive-behavioral principles and methods are used to provide the offender with a framework for understanding and facilitating change. These methods include: motivational enhancement and building treatment responsiveness, trust and rapport, relapse and recidivism prevention, and utilization of community self-help programs.

<u>Populations served:</u> To be determined after evaluating this pilot project.

<u>Populations that would not benefit from this treatment philosophy:</u> To be determined after evaluating this pilot project.

Relapse Prevention and aftercare services: To be determined after evaluating this pilot project.

• Multi-Systemic (MST) Therapy Approach

<u>Philosophy and supporting theories:</u> Multi-Systemic Therapy (MST) is an intensive family-and community-based treatment approach that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. MST addresses the multiple factors known to be related to delinquency across key settings, or systems including home, school, peers, and the community within which youth are embedded. MST strives to promote behavior change in the offender's natural environment, using the strengths of each system to facilitate change. The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems.

<u>Populations served:</u> Appropriate for chronic, violent, or chemical abusing juvenile offenders who are at high risk of out-of-home placement.

<u>Populations that would not benefit from this treatment philosophy:</u> Not appropriate for low risk juvenile offenders.

<u>Relapse Prevention and aftercare services:</u> Treatment aims to empower families to address current and future problems with the support of a social network of friends, neighbors, and extended family.

WRAP- AROUND Services

<u>Philosophy and supporting theories:</u> WRAP-AROUND programming and services are designed to help offenders with complex needs with the support of their families. Rather than plugging offenders into service programs to "fix" their problems, or carving their planning up between school, social services, and criminal justice, WRAP-AROUND, at its best, looks at the offender and family as part of an entire community, as individuals and a unit with strengths and needs that are unique. WRAP-AROUND has proven successful especially when offenders are facing difficulties in more than one area or are already involved in multi-agency services. The process of providing WRAP-AROUND services plays a strong role in determining the options for stabilization when an offender is displaying behavior management difficulties, and provides the best chance of success.

<u>Populations served</u>: Appropriate for offenders facing difficulties in more than one area (such as having chemical dependency and mental health issues) already involved in multi-agency services.

Populations that would not benefit from this treatment philosophy: Low risk juvenile offenders.

<u>Relapse Prevention and aftercare services:</u> Each juvenile that participates in WRAP-AROUND services has a WRAP team that includes family members, probation officers, social workers, school personnel, informal community support persons and a WRAP coordinator. A WRAP team meets on a regular basis and works with juveniles to develop a plan for aftercare services so that treatment gains are not undermined once he/she returns to the community.

Conclusions:

- There are many chemical health treatment modalities and options available to individuals with chemical abuse problems. DCCC and community-based chemical health treatment services incorporate best practices principles for effective chemical dependency treatment programming.
- There is a need to develop, at both the state and county levels, methods of system integration, coordination and communication to ensure that offenders' needs are meet.
- Treatment programs should provide offenders with individualized service plans tailored to their unique needs because "one size does not fit all".

Research Objective # 3: To learn more about chemical health treatment outcomes for offenders.

Findings # 1: Overall Treatment Outcomes

In an analysis of state and county data on treatment admissions taken from DAANES and other state, local and internal resources, Community Corrections planning team provided CCAB members with the following findings on chemical health treatment outcomes for offenders:

- <u>Entering Treatment:</u> As previously indicated, 1,972 Dakota County residents entered chemical dependency treatment in 2001. Fifty-six percent of these residents entered treatment through the courts or correctional system. Approximately 9 percent of all residents in treatment were from communities of color. Thirty-four percent of county residents who enter treatment do not complete treatment services. Eighty percent of chemical dependency treatment admissions in Minnesota and Dakota County are related to alcohol or marijuana abuse. According to the 1999 Minnesota's Treatment Outcomes Monitoring Report, 65 percent of all individuals in treatment have probably been through treatment before. Eighty-percent of all treatment admissions for the state and Dakota County are related to alcohol and/or marijuana abuse and most of these individuals have been through treatment before.
- <u>Barriers to Treatment:</u> Approximately 34 percent of Dakota County residents, who entered chemical dependency treatment in 2001, did not complete treatment. Here are some of the barriers they listed: 15 percent listed mental illness as the most common barrier and 3 percent reported a learning disability as a barrier. Twelve-percent leave against staff advise or are discharged because of noncompliance or behavioral problems. Many of the remaining individuals are transferred elsewhere.
- <u>Length of Stay:</u> Thirty-four days is the average length of stay for all inpatient treatment and the minimum number of outpatient treatment hours for both the state and County residents in treatment is 60. However, the range of treatment episode durations or services within each setting cannot adequately be determined.

- <u>Continuing Care/Transitional Care(Aftercare)</u>: Approximately 53 percent of individuals from the County who complete treatment is referred to continuing care services at the time of discharge to continue their recovery efforts.
- <u>Juveniles in Treatment:</u> According to results reported in the 1999 Minnesota's Treatment Outcomes Monitoring Report, a seven-year project that summarizes treatment outcomes findings of the 28,486 individuals who entered chemical dependency treatment, 12 percent were under the age of 18. The majority of juveniles in treatment had spent time in a detention center; and more than one-third had been referred to treatment through the courts or correctional system, having been arrested for alcohol or drug-related offenses.
- <u>Repeat admissions:</u> According to the DAANES report, 40 percent of adults had two or more treatment admissions. Repeat admissions for chemical dependency treatment were high for juvenile 42 percent. Among juveniles, the most striking difference between repeat admissions and first-time admissions was a history of psychiatric hospitalization. Twenty-three percent of adolescents in treatment for the first time had been hospitalized previously for psychiatric problems, the rate rose to 35 percent for those with one prior chemical dependency treatment admission, and 49 percent for those with two or more treatment admissions.

<u>Findings # 2: Treatment Outcomes for DCCC's Intervention Programs and Services</u> Safe Street First:

- <u>One-year follow up</u>: Program Participants Existing Between 1/1/95 and 12/31/99: 811 participants completed the program and 849 did not complete. Within one-year of leaving the program: 8 percent of the participants who completed the program had DWI offenses; and 12 percent of those who did not compete had DWI offenses.
- <u>Two-year follow up</u>: Program Participants Existing Between 1/1/95 and 12/31/98: 669 participants completed the program and 712 did not complete. Within two-years of leaving the program: 10 percent of the participants' that completed the program had DWI offenses; and 13 percent of those who did not complete had DWI offenses.
- <u>Three-year follow up:</u> Program Participants Existing Between 1/1/95 and 12/31/97: 518 participants completed the program and 371 did not complete. Within three-years of leaving the program: 8 percent of the participants who completed the program had DWI offenses; and 12 percent of those who did not compete had DWI offenses.
- <u>Five-year follow up:</u> Program Participants Existing Between 1/1/95 and 12/31/96: 343 participants completed the program and 371 did not complete. Within five-years of leaving the program: 9 percent of the participants who completed the program had DWI offenses; 15 percent of those who did not complete had DWI offenses. Note: There was no follow-up at four years.

Cognitive Behavioral/Chemical Dependency:

• This program was recently implemented in DCCC as a pilot project. There are not data statistics to report at this time.

Juvenile Program Outcomes:

- A preliminary evaluation of CD treatment outcomes data showed that of the 360 on supervised probation, 117 were assessed as high risk by the Y-LSCMI screening assessment and had chemical use as a major risk factor. Seventy-four (63%) of the 117 high-risk juvenile offenders had a CD evaluation conducted in 2001 by a managed care or a Chemical Dependency Consolidated Treatment Fund provider. As a result, 47 (40%) treatment referrals were made. Only 15 (13%) offenders successfully completed treatment. Of those offenders that completed treatment, the factors that appeared to impact treatment success included family involvement and motivation to change. It is also interesting to note that 82 (70%) of the 117 juveniles also had a mental health diagnosis, which demonstrates the prevalence of dual disorders.
- In evaluating reasons why offenders were not referred for a chemical dependency assessment, interviews with probation officers indicated low motivation to change and high probability for delinquent behaviors led to placement or programming to deal with antisocial behaviors compared to chemical use. Another factor that may have impacted the success ratio is that 63 percent of the juveniles referred to treatment did not have supportive services such as in-home family counseling or mental health services along with CD treatment as indicated by best practices.

- <u>Multi-Systemic (MST) Therapy</u>: For the past two years, Dakota County has conducted ongoing research of MST in collaboration with the Medical University of South Carolina. As indicated, MST addresses a broad array of barriers in the family and in the community in order to attain the defined treatment goals of the offender. National research indicates that MST has been effective in reducing criminal recidivism for juveniles by up to 70 percent in a number of randomized clinical trials. The U.S. Surgeon General in his 1999 report to the nation on mental health endorsed MST. DCCC does not have outcome numbers, for our local MST program, to report at this time.
- <u>WRAP-AROUND Services</u>: In 2000, the DCCC completed an outcome analysis of WRAP-Around program services. The results showed that 41 percent of the juveniles involved in WRAP services demonstrated a reduction in risk for educational and behavioral problems. By comparison, juveniles on traditional probation did not exhibit any major reductions in any of the risk factors. The Y-LSCMI was used every six months to assess risk factors. In evaluating offense histories for juveniles involved in WRAP services, there was a 100 percent reduction in felony level person offenses, an 86 percent reduction in all other felony level offenses, an 82 percent reduction in person misdemeanor offenses, and a 40 percent reduction in all other misdemeanor offenses. Overall, there was a 72 percent reduction in delinquent offenses for juveniles involved in the WRAP-Around program. In evaluating the cost effectiveness of WRAP services, results showed a 40 percent reduction in costs. The average yearly cost of services for a child participating in the WRAP is about \$3,000. Prior to implementing WRAP services, the average yearly cost of services cost of services for a child was \$5,000.

• DAWACA- (Dakota County-Washington County Chemical Abuse Joint Advisory Committee)

In November of 2000, juvenile correctional supervisors for Dakota and Washington Counties began discussing the relationship between high criminal recidivism rates, chemical abuse, and the dismal rates of chemical dependency treatment outcomes for juvenile offenders in their respective justice systems. As a result of their discussions, DAWACA was formed is to develop and implement a systematic research-based process to evaluate, integrate and improve the effectiveness of interventions and treatment program outcomes for chemical abusing juvenile offenders involved in both counties juvenile justice systems. Committee members have developed a community-based chemical dependency treatment model for Dakota County and a model for treatment services housed at the JSC. Both models will be implemented in the fall of 2002.

Conclusions:

- Treatment completion is the most consistent predictor of abstinence for both adult and juvenile
 offenders. However, there is a need to understand why individuals do not successfully complete
 treatment, and how treatment providers address treatment barriers as contributing factors to
 chemical abuse.
- Although the study findings do not definitively show treatment completion rates for individuals
 from communities of color and women, other research suggests that cultural and/or genderspecific treatment programming is effective. Improving treatment outcomes and using health care
 resources efficiently are two direct benefits of placing individuals in treatment programs that
 match their needs.
- Safe Streets First (SSF) is an effective intervention program; it reduces the number of staff needed to monitor program participants, and reduces the number of jail beds needed. Because participants are required to pay for services directly, SSF is also a self-supporting, cost-effective intervention program. The Cognitive Behavioral/Chemical Dependency (COG/CD) pilot project may also prove to be an effective chemical dependency intervention service.
- Multi-Systemic Therapy (MST) and WRAP-AROUND services have proven effective in reducing the risk of criminal recidivism among juvenile offenders.

Research Objective # 4: To assess funding sources available to DCCC's offenders for chemical health treatment services.

Findings # 1: Funding sources

CCAB members learned that people in the state of Minnesota pay for chemical health treatment services in a variety of ways, such as self-pay, private (managed care) health insurance, and publicly funding programs such as Medicare and Medicaid, MinnesotaCare, Medical Assistance, Chemical Dependency Consolidated Treatment Funds and other programs. Data from the 1999 Minnesota's Treatment

Outcomes Monitoring Report indicates that for the majority of Minnesota residents who enter chemical health treatment, services are paid for with public funds.

The county contracts with a variety of chemical health treatment providers. Depending on how these programs are licensed, they serve individuals seeking treatment, adults and/or juveniles, men and/or women, in either in-patient or outpatient settings. Contracted services include alcohol, drug, mental health assessments, individualized treatment planning, individual and group counseling, family education, referrals, and continuing care services.

Service rates are set by current market rates. Rates for Dakota County increased by 3 percent from 2001 to 2002. Hourly rates for outpatient treatment programs in Dakota County ranged from \$22.51 to \$28.56 for adults and from \$23.07 to \$24.40 for adolescent programs. Statewide a typical, "low-end" cost for outpatient treatment is \$21.85 per hour for a 60-hour outpatient program. "High-end" cost is typically \$32.50 per hours for a 60-hour outpatient program. The average cost for a publicly paid primary care treatment episode is 3 times higher for in-patient services (\$4,200) than for outpatient (\$1,400).

In Dakota County managed care providers accounts for 75 to 80 percent of funding for outpatient chemical health services, while Chemical Dependency Consolidated Treatment Funds pays for 75 percent of inpatient care. For the fiscal year 2002, the county has expended 100% of its \$1,497,326 allocation from the state for the Chemical Dependency Consolidated Treatment Fund. Approximately 760 treatment placements have been to date. For 2001, the County's total Chemical Dependency Consolidated Treatment Fund expenditures were \$2,243,224 for 705 treatment placements compared to \$2,089,988 for 694 treatment placements in 2000. Dakota County's Chemical Dependency Consolidated Treatment Fund expenditures are similar to those of Ramsey, Anoka and Washington counties.

Conclusions

- Funding drives treatment services. Limited Chemical Dependency Consolidated Treatment Fund dollars are used to pay for expensive treatment services.
- New funding streams are necessary to effectively serve individuals in need of chemical health treatment services. One "new" source may be Medicaid dollars since these funds have been successfully used to pay for other types of treatment services.

Recommendations

The board's recommendations to DCCC for improving chemical health services for offenders are as follows:

Chemical Health Treatment

- Survey local treatment providers, insurance providers and individuals who receive treatment to learn more about why individuals do not complete treatment and how treatment barriers are addressed.
- Track and analyze treatment outcomes over time to measure system performance, examine effects of chemical use on criminal recidivism and determine appropriate resource allocations.
- Ensure that contracts with chemical health treatment providers offer integrated systems of care, and cultural and gender-specific programming.
- Implement a pilot in-patient CD treatment program at DCCC's Juvenile Services Center.
- Incorporate WRAP-AROUND services into chemical health treatment intervention services for juvenile offenders.
- Evaluate the possibility of using the WRAP-AROUND service model for adult offenders; if deemed appropriate, implement a WRAP-AROUND pilot project.
- Re-evaluate Safe Street First outcome data to prevent generalizing the program's effectiveness.
 DCCC may need to secure funding to conduct an in-depth assessment of SSF treatment outcome data to clearly determine whether or not the program is effective.

Continuing Care/Transitional Care Services (Aftercare)

- Evaluate the effectiveness of DCCC's Cognitive Behavioral/Chemical Dependency pilot project for adult offenders and explore this as an option for continuing care.
- Expand Multi-Systemic Therapy and WRAP-AROUND services as a component of continuing care services for juvenile offenders.

- Consult with insurance companies to develop incentives for service providers to fund chemical health continuing care services.
- Evaluate outcomes of continuing care services to determine the impact on the offender's success
 at remaining alcohol and drug free. Determine if current continuing care/transitional services are
 adequate to meet the needs of offenders.

Funding

- Collaborate with Hennepin and other interested counties in pursuing Medicaid dollars to pay for chemical health treatment services.
- Explore the possibility of expanding the Chemical Dependency Consolidated Treatment Fund.
- Explore legislation on court-ordered treatment as a way for insurance providers to pay for broader (dual diagnosis) treatment services.
- Evaluate the impact of new DWI laws and how to successfully incorporate statutory language requirements into treatment and intervention services.

Training

- Develop and implement cross-training among criminal justice agencies, social services agencies, and insurance companies to:
 - 1. provide information about the complex needs of offenders with chemical health issues,
 - 2. ensure that information provided to offenders about chemical health treatment services is consistent.
 - 3. improve offender access to services, and
 - 4. roll out "best practices" treatment approaches.

Respectfully submitted by:

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